## Attachment 1 Question 7d and Question 15 DEPARTMENT OF HEALTH CARE POLICY AND FINANCING

## QUALITY IMPROVEMENT AND DISEASE MANAGEMENT PROGRAMS

Immunization project: The immunization project is a collaboration with the state immunization registry, the Colorado Immunization Information System, to provide more accurate data regarding the immunization status of children enrolled in Medicaid. Currently, the data for children's immunization rates is collected via the Healthcare Effectiveness Data and Information Set protocol, which includes a claims review plus a chart review for a sample of the eligible population. Since many children are vaccinated outside of their doctor's office, many vaccinations are missed with the Healthcare Effectiveness Data and Information Set collection method. Combining Healthcare Effectiveness Data and Information Set with Registry data will provide more accurate information regarding rates of immunization for children on Medicaid. If Centers for Medicare and Medicaid Services approves the plan for collaboration, there will be a 50% federal match for the state registry.

Focused Studies: The Department's external quality review organization conducts two focus studies each year. Two studies are being conducted this year. The first assesses the rates of adolescent well child visits for children aged 12-18 in the Medicaid program, and identifies missed opportunities when an adolescent visits a provider but a well-child visit is not conducted. A second study addresses coordination of care for clients receiving both physical health and behavioral health services. All Medicaid managed care organizations for physical health and behavioral health will be participating in this second statewide study to identify the extent to which physical and behavioral health providers coordinate care for clients with a serious mental illness diagnosis. This project requires each managed care organization to institute an intervention to improve coordination of care and to track to see if that intervention is effective.

Consumer surveys are conducted for both children and adults to determine how Medicaid clients perceive their quality of care.

Implementation of Medical Home (Senate Bill 07-130) legislation and Senate Bill 07-211: these two pieces of legislation mandate the Department to implement systems to provide a Medical Home for all children on Medicaid and the Children's Basic Health Plan and to monitor Medical Homes for quality of care. Specifically, one mandate of Senate Bill 07-211 is that the Department consults with external clinical advisors to make recommendations for performance measures for specific clinical activities to build accountability into Department programs. For the Medical Home bill, the Department is working closely with the Colorado Department of Public Health and Environment on implementing the Medical Home bill and creating standards for defining and measuring Medical Homes.

Provider profiling: On a quarterly basis, the quality improvement section creates a newsletter with a provider profile focused on a topic related to access to care or quality of care. The profile is personalized for each provider and identifies clients on the providers' panel that may be in need of the highlighted service. For example, the most recent newsletter highlighted immunization rates for children under 2 years old and included a list of the clients assigned to the provider's panel that, according to our records, are due for immunizations. Historically, profile topics have included: rates of preventive care for children, immunization rates, rates of preventive care for adults, and emergency department utilization rates.

Quality Intervention: Each year, our external quality review organization conducts a targeted intervention based on priorities established by the Department. This year, a survey will be conducted that is designed to identify barriers to care for the women in the Primary Care Physician Program and the Fee for Service program who did not receive timely prenatal care. This survey will allow the development of future interventions that better target barriers to care for the women not accessing care.

Performance Measurement: The Department uses the Healthcare Effectiveness Data and Information Set measures to assess the quality of care clients enrolled in Medicaid and the Children's Basic Health Plan receive. These measures are chosen in collaboration with the Children's Basic Health Plan and the Medicaid physical health managed care organizations.

Return on Investment forecasting calculation tool: The Department was selected by the Center for Health Care Strategies to be one of eight states to test this forecasting tool. The tool is used to calculate the forecasted return on investment for several disease management programs as well as a predicted return on investment on the Medical Home project.

Annual Site reviews: Each year, the Department conducts site reviews of all the contracted behavioral health and physical health organizations that serve Medicaid clients. The foci for the site reviews in FY07-08 are: quality assurance, utilization management, the grievance & appeals process, the Early Periodic Screening, Diagnosis and Treatment program, preventive services, and licensure & credentialing of providers, as well as corrections made to problems identified from the previous years' site reviews.

Long-term Care & Home and Community Based Services Activities: The quality improvement activities for Long-term Care and the Home and Community Based Services waiver include three areas of focus. The first focus area is identification of problems and necessary improvement for Medicaid's Alternative Care Facilities. The Alternative Care Facilities provide housing for the Home and Community Based Services for clients who are Elderly, Blind and Disabled and Persons with Mental Illness. The second focus is the creation and implementation of a Critical Incident Reporting System for Home and Community Based Services administered by Single Entry Points agencies. Finally, the Department is investigating the possibility of implementing training provided by Department for the Single Entry Point agency case managers. Currently, individual

Single Entry Points agencies are required to train each new Single Entry Point agency case manager. The high turnover of case managers has proven to be burdensome on Single Entry Point agencies in providing this training. The Department is exploring the possibility of implementing and seeking funding to provide basic standardized training, in addition to the yearly training currently conducted by the Department.

## Disease Management Programs

The Department's disease management program consists of six already-existing or anticipated individual programs or contracts. Each program is described below:

Asthma: The Department contracts with Alere Medical, Inc. to administer the asthma disease management program. The program started as a pilot in October 2002 and was implemented statewide in November, 2004. The Department has identified over 30,000 clients with a diagnosis of asthma, the majority of which are children. Clients eligible for the program have asthma as their primary or secondary diagnosis and have more than \$800 in paid claims in the previous 12 months. Total annual medical and pharmacy claims cost equal \$165M. Clients in the asthma program are identified through monthly downloads provided by the Department. Once enrolled into the asthma program, the client receives a welcome letter with educational materials and a breathing monitor. The client then receives an introductory call, followed by 3-6 additional calls from registered nurses over the course of 12 months based upon the severity of the condition. During this time, updates are provided to the client's physician as needed. After a year in the program, if the client is on appropriate medications and has had no asthma related emergency room visits or hospitalizations for 6 months, the client is graduated out of the program. In the first six-months, the program achieved a return on investment of 2.84 and missed days of school/work for enrollees decreased by 90%.

Telehealth Pilot Program for Chronic Conditions: the Department contracted with Specialty Disease Management starting in July 2007 to serve 165 clients with one of three chronic illnesses: congestive heart failure, chronic obstructive pulmonary disease and/or diabetes as their primary or secondary diagnosis. The program was started to fulfill the mandate of Senate Bill 06-165, Section 25.5-5-701, C.R.S.(2006), requiring the Department to issue a request for proposals to conduct pilot programs to investigate the feasibility of managing and treating clients with specified chronic medical conditions, including chronic heart failure, diabetes and chronic obstructive pulmonary disease, using telemedicine whenever appropriate. Clients are identified through monthly downloads provided by the Department. Clients eligible for the program have, and have been determined to be high cost and/or high risk. Once enrolled, the client is provided with inhome tele-monitoring equipment that allows for the use of multiple peripherals including a Glucometer, weight scale, blood pressure, pulse oximeter, and spirometer, as appropriate for the condition being managed. Client measurements are transferred to a nurse station through the telephone line to allow remote evaluation of the client's condition. Measures determined to be outside patient-specific parameters set by the client's physician prompt follow up from a registered nurse and physician notification.

Congestive Heart Failure: The Department contracted with Alere Medical, Inc. in July, 2007 to better manage clients with congestive heart failure. Congestive heart failure is the

second most costly chronic diagnosis for inpatient costs, and has an annual total medical and pharmacy claims cost of \$43M. Clients eligible for the program have congestive heart failure as their primary or secondary diagnosis. Once enrolled, high risk clients are provided with a biometric home monitor with scale. Clients unable to use a scale are provided with a symptom-only monitor. Client measurements are transferred to a nurse station through the telephone line to allow remote evaluation of the client's condition. Measures determined to be outside patient-specific parameters set by the client's physician prompt follow up from a registered nurse and notification to the physician. Clients who are unable or refuse to use an in-home monitoring device receive telephonic assessments as frequently as required by weight and symptoms.

Chronic Obstructive Pulmonary Disease: The Department contracted with Alere Medical, Inc. in October 2007 to manage clients with chronic obstructive pulmonary disease. Chronic obstructive pulmonary disease is the third most common chronic diagnosis among Colorado Medicaid adults with an annual total medial and pharmacy claims cost to the Department of \$46M. This program is designed to decrease costs of chronic obstructive pulmonary disease to the Department. Clients are identified through monthly downloads provided by the Department. Clients eligible for the program have chronic obstructive pulmonary disease as their primary or secondary diagnosis. Once enrolled, high risk clients are provided with a biometric home monitor. Client measurements are transferred to a nurse station through the telephone line to allow remote evaluation of the client's condition. Measures determined to be outside patient-specific parameters set by the client's physician prompt follow up from a registered nurse and notification to the physician. Clients who are unable or refuse to use an in-home monitoring device receive telephonic assessments as frequently as required by symptoms.

High-Risk Obstetrics: The Department anticipates contracting with Matria Healthcare in December 2007 to address costs and complications resulting from high-risk pregnancy outcomes. Recent studies show that Colorado ranks 48<sup>th</sup> nationally in access to prenatal care and 45<sup>th</sup> in the nation for pre-term births and low birth weight babies. Fourteen of the 15 top diagnoses, ranked by dollars, were related to high-risk pregnancy, totaling \$69M in hospital claims paid by Colorado Medicaid for FY05. Annually, Colorado Medicaid covers approximately 24,500 deliveries. Clients may self-refer into the program, be referred by a physician or be identified through monthly downloads provided by the Department. Clients who are screened and determined to be high-risk are contacted and educated through written materials, including a comprehensive book which outlines both the healthy progressions of pregnancy as well as high-risk conditions which may occur. Clients may also access information via the Web and will receive regularly scheduled outreach calls from a program nurse. Interactions are tailored to each client's needs. Clinical alerts trigger nurse interventions, focusing on an appropriate care plan.

Weight Management: the Department anticipates contracting with National Jewish Medical & Research Center in February, 2008 to address concerns and costs related to poor weight management. A data pull from 2003-2005 revealed approximately 10,000 Medicaid clients with a diagnosis of obesity. Just over 7,000 of these clients also have a diagnosis of high blood pressure, heart failure, and/or diabetes that generally result from being obese. Annual claims dollars for these identified clients were \$104.5M. Clients must have a body mass index of > 25 and may self-refer into the program, be referred by

a physician or be identified through monthly downloads provided by the Department. This program emphasizes lifestyle modification through health education and increased activity levels. This program will operate cohesively with the Department of Public Health and Environment's weight management program by focusing on the 43 counties not currently being served by the Colorado Department of Public Health and Environment.